Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Stephen E Earle

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-14-0839-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These codes were preauthorized by your office."

Amount in Dispute: $10,125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual paid the electrodes removal and the support implant, and argues no additional payment is due per the IRO decision."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2013	Outpatient physician services	$10,125.00	$1,500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support the services were preauthorized?
2. What is the applicable rule for establishing fees?

3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 197 – "Precertification/authorization/notification absent." 28 Texas Administrative Code §134.600(p) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services…" Review of the Independent Review Decision finds the following, "…it is the opinion of the review that the requested inpatient lumbar surgery; removal EBI electrode units, removal of transmitter w/possible exploration of arthrodesis, laminectomy; revision lumbar spine surgery at L3/4 L4/5 w/LOS x 1 is recommended…" Review of the submitted medical bill finds the following codes and descriptions;

Code	Description	Review of Documentation	Additional Payment
63662 – 51	Removal of spinal neurostimulator electrode plate/paddles(s) placed via laminotomy or laminectomy	Procedure paid, no documentation found to support multiple procedures	No
22830 – 59	Exploration of spinal fusion	Recommended by IRO	See below
22899-99	Unlisted procedure code, spine	Not supported by operative report, not part of IRO recommendation	n/a
63042	Laminotomy	Not supported by operative report, not part of IRO recommendation	n/a
63042 – 50	Laminotomy	Not supported by operative report, not part of IRO recommendation	n/a
63044	Laminotomy	Not supported by operative report, not part of IRO recommendation	n/a
63044 - 50	Laminotomy	Not supported by operative report, not part of IRO recommendation	n/a

   The Division finds the carrier's denial is supported except for code 22830 which will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.203(c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (current year conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (current year conversion factor).

   Procedure code 22830, service date August 5, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 11.22 multiplied by the geographic practice cost index (GPCI) for work of 1 is 11.22. The practice expense (PE) RVU of 10.07 multiplied by the PE GPCI of 0.912 is 9.18384. The malpractice RVU of 2.9 multiplied by the malpractice GPCI of 0.809 is 2.3461. The sum of 22.74994 is multiplied by the Division conversion factor of $69.43 for a MAR of $1,579.53. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $1,500.00.
3. The total allowable reimbursement for the services in dispute is $1,500.00. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $1,500.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.